Maternal care in Georgia

Summary

Cost, access and quality of maternal care are concerns in health systems all over the world. Maternal health depends on the functioning of the health system of a country. Although some countries have made efforts to reduce the fee-for-services for maternal care in recent years, good quality maternal care still remains too expensive for many women. It also should be emphasized that better access to maternal care services is not sufficient to improve maternal health outcomes. The quality of care a woman receives during pregnancy, childbirth and postpartum affects her health, the health of her child and her and her child's future life. Remarkably, the potential impact of cost, access and quality on pregnancy outcomes during health system reforms on maternal care has been largely unexplored. In this context, the dissertation evaluates the cost, access and quality of maternal care in a health system in transition. In particular, the dissertation focuses on the capital and two regions of Georgia, where these aspects of maternal care provision are especially problematic. The key stakeholders' opinions and evaluation of maternal care are also taken into account.

The aim of this dissertation is to examine access, quality and financing of maternal care services in Georgia. The dissertation consists of seven chapters. Below, the main findings from each chapter are summarized.

Chapter 1 presents a broad overview of the development of the health system in Georgia, as well as the current status. The chapter also outlines the concept of access, quality and financing. We focus on these aspects of maternal care in Georgia. We provide this background information to understand the results of the dissertation. In this chapter, we also outline the aim, objectives and methodology used in this dissertation. As mentioned above, the aim of this dissertation is to examine aspects of access, quality and cost of maternal care in Georgia. To achieve this aim, we first explore the empirical evidence on the outcomes of the reform to provide an evidence-based appraisal of the reform (Chapter 2). Furthermore, we assess the changes in maternal care during the healthcare reforms in Georgia (Chapter 3). In Chapter 4 and 5, we explore the adequacy of maternal care financing and access of mothers of such services in Georgia and study factors influencing maternal care in terms of quality and access. Chapter 6 addresses women's satisfaction with maternal care services in Georgia. Chapter 7 presents the main findings of the dissertation followed by suggestions for further research and policy recommendations.

In this dissertation, we used a combination of research approaches. In Chapter 2, we used a systematic review of the empirical evidence on the outcomes of the healthcare reforms in Georgia. In Chapter 3, we carried out secondary analysis on three waves of the Reproductive Health Surveys (RHSs) of Georgia which were conducted in 1999-2000, 2005 and 2010. In Chapter 4 and 5, we applied qualitative data analysis. Data for the

analysis in Chapter 4 and 5 are obtained from a qualitative study among the following stakeholder groups: women who had used maternal care services during the past 4 years, healthcare providers and decision makers (health-care policy makers, health insurance representatives, representatives of international organizations). Due to the different characteristics of the groups (e.g. size, diversity), qualitative data among women were obtained through focus group discussions (FGDs), 6 group discussions in total. The data among the other stakeholders were obtained through face-to-face in-depth interviews (IDIs) (15 interviews). In Chapter 6, we used data from a cross-sectional survey specifically conducted for this dissertation to study women's satisfaction with maternal care.

In Chapter 2, we review the empirical evidence on the effects of the healthcare reforms in Georgia. The objective of this systematic literature review is to identify the challenges for health financing and universal access to healthcare and to determine interventions that may help to overcome barriers to the implementation of the reforms. It reviews the healthcare reforms in Georgia on their financial sustainability, allocative and technical efficiency, equity in access and finance, transparency and accountability, utilization and quality of care.

Only 38 articles and reports in English and 3 in Georgian met the relevant criteria and presented evidence-based data. Overall, the evidence presented in the studies reviewed, was not enough to conduct a thorough impact evaluation of the healthcare reform of the Georgian healthcare sector. This is due to the limited number of studies and limitations of each study. However, our analysis outlines several conclusions relevant to policy and research.

Our results suggest that the initial goal to reorganize the post-Soviet healthcare sector was achieved after several stages of healthcare reforms. The country faced multiple challenges during the reforms. The direction and priorities of the reforms depend on the ruling party and this corroborates the principal – "new lords, new laws". A high-level of out-of-pocket payments (OPPs) accompanied the healthcare reforms since independence. Given the resource constraints people face, the utilization of healthcare services fell dramatically during the last two decades. The total privatization and liberalization of the health market made the Georgian health reform unique. The decision to privatize nearly all public health facilities was motivated by the obsolescence of the Soviet healthcare infrastructure. The financial crisis, weak governance, population dissatisfaction and a strong influence of private investors on the government played also a significant role in the privatization decision. In the private market, there were mergers between pharmaceutical companies and health facilities. Supplier induced demand for healthcare services were quite common in the private

health market. Due to a lack of regulatory control over the costs, healthcare providers increased their fee-for-services. As a result, the potential risk of catastrophic health expenditure increased.

In the second stage of the reform, private health insurance was established in the country. The insurance companies freely manipulated the selection criteria and risk-rated premiums concentrating on their own profits. Increased OPPs created barriers for access to healthcare services and compromised equity. At the same time, the market-based health system had a negative effect on the quality of healthcare during the second stage of the healthcare reform.

The 2013 Universal Health Coverage (UHC) program was implemented in the country. Since the implementation of the "Health for All" program, the government has taken steps to improve the quality of care. The perinatal service providers have been graded by their functional capabilities and a reorganization of the referral and emergency system has started.

Chapter 3 assesses the changes in maternal care during the different stages of the reforms as well as their effect on the utilization of maternal care. In particular, we analyzed the data of three waves of the RHSs which were collected in 1999– 2000, 2005 and 2010. As outlined in Chapter 3, the previous literature has considered that during the Soviet period, women in Georgia gave birth in large, damp, cold maternal rooms, four to six women in a room, without a partner or family being present. It was a necessity to transform maternal care and the country-initiated healthcare reforms including a maternal care reform. The reform of the maternal health system was necessitated by the high and increasing pregnancy-related mortality and morbidity.

In Chapter 3, we present a secondary analysis of the three RHSs. For the assessment, from all three waves of the RHSs, we selected a sample of women who had experienced childbirth during the last 5 years. In total, 7684 respondents from all three waves met the inclusion criterion. We only analyzed data on pregnancy outcome, type of childbirth, access and utilization of antenatal, natal and immediate post-natal care, as these are the main indicators for the evaluation of maternal health and maternal care. We also used socio-demographic and health status characteristics of the women-respondents. Descriptive, binary and multinomial analyses were performed.

Our findings show that maternal care changed during the healthcare reforms. In 1999, during the first stage of healthcare reform, the State implemented the national program on the development of reproductive services with several components, such as family planning, STI-AIDS/HIV, antenatal and perinatal, surveillance, sexual education; and training for health professionals. The State implemented four free antenatal

care visits which was a progressive policy approach. Utilization of antenatal care services from the very beginning of the implementation of the program was quite high (92.1%). This increased to 95.1% in the second wave and 98.2% in the third wave. The places where women received maternal care, particularly antenatal care changed through the years.

Antenatal services were provided mostly by the primary healthcare centers, such as rural dispensaries or women consultation center during the first wave. However, the centralized public provision of healthcare was reformed into a market-based system through a massive privatization of healthcare facilities and the delivery system including maternal care. Accordingly, the last wave shows that antenatal care services were provided only by women consultation centers or by the maternal houses.

The second stage of the healthcare reforms started with the privatization of maternal houses and women consultation centers. Consequently, due to private owners' interest, the use of private antenatal services increased between 1999 and 2005. During this period, the number of providers of antenatal care services increased as the maternal houses started providing antenatal check-up and they established women consultation centers within the maternal houses. More women could freely use antenatal services in maternal houses and choose their own provider, i.e., "personal doctors". In the market-based health system, competition between providers to deliver good quality care became evident, which was nearly absent during previous centralized health system.

Similar to studies in other countries, we found that a significant predictor of the use of antenatal care visits in Georgia is education: low and mid-level educated women utilize maternal care services less often than higher educated women. Moreover, rural women utilize such services less. The healthcare reforms in Georgia aimed to ensure access to the basic services including maternal care services, specifically antenatal care. However, there are additional factors that also influence access to services such as religion and socioeconomic status. All these factors were strong predictors of the use of services and they play a role even if access to basic antenatal service is ensured. The RHS waves provide limited information about the quality of maternal care. The presented secondary analysis only provides proxy indicators of quality of maternal care, like blood pressure measurement and utilization of ultrasound examination during the last pregnancy of respondents, which had gradual increasing trends over the years.

In Chapter 4, we presented a qualitative study to explore the opinion of key stakeholders about the adequacy of maternal care financing and financial protection of pregnant women in Georgia. This chapter contains the results of six FGDs and fifteen face-to-face IDIs, that were conducted in the capital Tbilisi, as well as in Adjara and

Imereti regions of Georgia. The study was done in 2015. Each FGD consisted of 7– 6 mothers who had utilized maternal care services during the 4 years. A total of 41 women (primipara n = 19; multipara n = 22) participated in six FGDs and 15 other stakeholders: Policymakers, medical doctors, and representatives of private health facilities, international organizations, and professional organization were participants of the IDIs. We used a mixed convenience and purposive sampling method to select these stakeholders depending on their known involvement and experience in maternal care.

We find that the privatization played a crucial role in service provision in maternal care as it influences the development of the health system. The decision of the government to privatize the entire health sector is an outcome of a policy-driven process, but it is not followed by strong regulation mechanisms and this gives room to private ownership of the maternal houses, to manipulate the user fees. The consensus among stakeholders showed that the 2013 UHC program was implemented to protect mothers from financial burden. However, weaknesses in regulation are also observed.

Chapter 4 also discusses the burden of OPPs for pregnant women in Georgia. We find that the antenatal care period as well as the natal period come with extra OPPs. The burden of OPPs increases in case of complications. Moreover, OPPs are also related to the phenomenon of a “personal doctor”. Overall, our results confirm that the current financial reform is regressive. Although both the poor and the rich have equal access to state facilities, whenever needed, the richer segment has access to specialized services through OPPs but the poor segment is not supported by the State program for the specialized services.

Chapter 5 describes the findings of a qualitative study on the stakeholders’ opinion on the quality of and access to maternal care in Georgia. Chapter 5 used data collected in the same qualitative study as the data for Chapter 4. As explained above, the study was conducted in 2015 and consisted of six FGDs (7–6 mothers per group) and 15 face-to-face IDIs with other stakeholders. The method of mixed convenience and purposive sampling was used to select these stakeholders.

We examined maternal care in terms of quality and access. Quality was divided into clinical quality, social quality, continuity of care and comprehensiveness of maternal care. We tested clinical quality by medical doctors’ knowledge and skills of diagnosis and treatment, medical doctors’ and nurses’ responsiveness, as well as the quality of lab investigations. We assessed the following aspects of social quality: maintenance of privacy and respect for the mothers, mental support, attentiveness to the problems presented, communication, and tangibility. Continuity was assessed in terms of mothers' adherence to doctors` advices and specific maternal care facilities. We also

assessed the effects of the doctor-client relationship on continuity of maternal care. The comprehensiveness of maternal care was assessed in terms of 'one door shopping'. Also, we assessed spatial access in terms of the geographical distribution of maternal care facilities both in rural and urban areas. Whereas, temporal access was assessed in terms of the respondents' opinions about waiting time for ambulatory and emergency care and the referral process.

Based on the analysis, we observed that the majority of respondents support maternal care reforms. However, our findings suggest that the lack of clinical skills of medical doctors is related to either misdiagnosis or delay in the identification of pregnancy complications. Continuity of care is interrupted because of the lack of skills of medical doctors, providers' financial interest and an ineffective referral system. Absence of continuous professional development (CPD) for physicians also negatively influences clinical as well as the social quality of care. Findings indicate urbanization of comprehensive maternal care in Georgia. Privatization also played a significant role in the concentration of services in the big cities. However, spatial access to basic maternal care services has been improved as a result of the UHC program. In general, there have been some improvements in the maternal care system. However, to meet the population's expectations and to achieve the target outcomes of maternal care, substantial improvements in quality and access need to be made.

In Chapter 6, we present the findings of a survey that was conducted in the capital and two regions of Georgia. In total, 400 women, who gave birth to healthy babies during the preceding twelve months before the date of data collection, were the target population. We measured women's opinion about the organization of maternal care (tangibility, availability, accessibility) and process features (responsiveness, reliability, empathy, communication and courtesy). We also studied women satisfaction with antenatal, natal and post-natal services.

Our findings indicate that the utilization of antenatal care is nearly 99.5% and most of the participants were satisfied with antenatal care services. About 85% of the respondents received more than eight antenatal care visits which are considerably more than the state- scheduled four visits. Our findings suggest that women with the lowest level of education, are more satisfied than women with the highest education level. Some studies have shown that higher education is associated with higher demands and expectations which in turn relate to lower satisfaction. Our results also confirm that women in urban areas are more satisfied with antenatal and natal services than those in rural areas. Pregnant women most often utilize services from the regional antenatal and natal providers rather than from the nearby rural-based facilities. Moreover, many rural women start receiving antenatal care from rural

facilities and often switch to providers in urban facilities which cause a breach of continuity of care.

Overall, our survey indicates that women are satisfied with maternal care in Georgia and that the basic maternal care services are ensured in the entire country. However, this satisfaction of women does not imply efficient use of resources invested by the government through the private health sector. We find that women in urban settings were more satisfied with the antenatal and natal services than in rural areas. Moreover, those who pay out of pocket are less satisfied.

Chapter 7 outlines the main findings of the dissertation, followed by the general conclusion and policy implications of the dissertation.

As discussed in this chapter, in almost three decades the Georgian health system changed from the Semashko model of health financing to a privatized one. Through this period the country implemented several healthcare reforms. Our findings indicate that efficiency and equity are influenced negatively by the changes in the health system. It resulted in a lack of cost control and client trust in the system.

The phenomenon of a “personal doctor” plays a significant role in maternal care services in Georgia. The term “personal doctor” was established already several decades ago in maternal care in Georgia. Due to substandard maternal care services, pregnant women and their households try to utilize services for antenatal care or/and childbirth from an obstetrician who is most popular in their environment. Our findings suggest that there are many determining factors to search and pay extra for a personal obstetrician, such as safety, responsiveness and personal comfort. Often pregnant women utilize antenatal care in one facility and have childbirth in another. This poses a big barrier for continuity of care. The price for a "personal doctor" varies between 300 GEL and 1000 GEL. Not everyone can afford a “personal doctor” which leads to inequalities and disparities among mothers. The State implemented free antenatal care visits and childbirth; however, pregnant women prefer to have a “personal obstetrician” from the very beginning of the pregnancy. Our findings indicate that having a “personal doctor” means extra antenatal visits and medical investigations. Thus safe, timely and patient-centered care under the State program is questionable. Another perspective of having a “personal doctor” is to maintain the autonomy of choice. At the same time, findings indicate that women pay for the “personal doctors” just to ensure the services that are already in the place. They pay because of “fear” and “positive word-of-mouth” that they are getting more than those who do not pay.

The fragmentation and absence of continuity of maternal care was inherited from the Soviet period. The organization of the maternal health system is still divided into two

parts, the antenatal care services and the maternal houses. After the transformation of maternal care, the number of independent women consultation centers decreased gradually. Thus, the antenatal care providers integrated into the maternal houses or units increased. Fragmentation of maternal care negatively influences maternal care quality as obstetricians involved in antenatal care did not have communication with those who work in the maternal ward. The absence of a link between antenatal and natal care providers compromises continuity, quality of maternal care and trust in the doctor and in the system. Thus, the 'do-it-yourself" approach was adopted by mothers and their relatives in Georgia as an alternative politics" to address the above-mentioned gap of the system.

The concentration of facilities in urban areas has influenced geographical and financial access to maternal care. Most of the maternal care facilities are concentrated in the capital which presents significant disparities in quality of care. This situation makes that pregnant women from the regions almost always prefer to utilize services in the capital. The concentration of the tertiary and secondary level facilities in the capital and big cities was inherited from the Soviet period. The Soviet approach to the distribution of medical facilities was maintained after independence. The first public-based tertiary maternal house was established in Tbilisi in 2003. Since then the most complicated or near-miss case were transported and managed in that particular maternal house. The preference to utilize services in the urban places is determined by the poor quality of maternal care in rural places. Also, the most popular and experienced medical doctors are concentrated in the regional centers and in Tbilisi. However, utilization of maternal care services in the capital and in the big cities come with direct and indirect costs which increase the financial burden for pregnant women, compromise financial access and equity in the country.

OPPs comprise one of the challenges of maternal care. As already mentioned most pregnant women have a "personal doctor" for antenatal as well as natal and immediate post-natal services and pay out of pocket. The cost of the services of "personal doctor" is quite high. However, to receive good quality maternal care is determined by healthcare delivery characteristics, such as access and quality of care. The childbirth expenses for all income groups are part of the UHC program and in 2017, the country implemented perinatal regionalization. In spite of this, almost all pregnant women are paying out of pocket. Our findings indicate that a high price does not ensure high quality of maternal care services. Moreover, those who pay are less satisfied and less motivated to recommend the services to others. Thus, maternal care is substandard and poses an extra financial burden on pregnant women in Georgia.

Our results suggest that geographical and financial access to the basic maternal care

services is ensured by the State maternal care programs. However, our results show some weaknesses in this policy, namely the high burden of OPPs, substandard quality of maternal care and lack of access to the comprehensive maternal care services.